Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: HEALTHTRUST, LLC PO BOX 890008 HOUSTON, TX 77289	MFDR Tracking #: M4-09-8351-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: INSURANCE CO OF THE STATE OF Box #: 19	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please give reconsideration to the dates of service listed below based upon the information that is provided to you below. Preauthorization was granted for a total of 20 multi-disciplinary chronic pain sessions. There has been payment of 15 of the 20 sessions in full. One date of service had a partial payment, with 4 dates of service being denied due to the lack of medical necessity for the procedure. These findings were based upon a peer review. However, the preauthorization was already granted and listed medical necessity as the reason for granting the original request. After several submissions for reconsideration, HealthTrust felt that an MDR was appropriate. As indicated in the code, once preauthorization is granted, medical necessity has been established. Please review this medical fee dispute and grant HealthTrust a decision that would allow payment for said services. HealthTrust has abided by the rules and guidelines as required in seeking preauthorization. HealthTrust performed as directed by the letter of the code set forth by the TDI-DWC. HealthTrust ask that ESIS be instructed to follow those same rules and guidelines. Due to the delay in payment, HealthTrust also seeks interest on these outstanding claims."

Amount in Dispute: $7,400.00*

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "1. The issue in dispute is: Date of service 9/26/08, 9/29/08, 10/3/08, 10/31/08 and 12/12/08. All charges are for $1,560.00 each for a total of 7,800.00. The amount in dispute is $7,400.00. The provider is Provider is {sic} Healthtrust, LLC. 2. It was denied on {sic} based on the following reason(s): Other: (List any reason other than the Audit Reviewer's findings) 3. The following documentation supports my position: Pre-authorization did not cover dates 9/26/08, 9/29/08, and 10/3/08 and therefore are not covered. Date of service 10/31/08 was submitted for processing with a recommended allowance of $400.00 which was paid to the provider. The bill was resubmitted and an additional allowance of 1,200.00 was recommended. A copy of the EOR and payment summary screen are attached."

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
9/26/08	97799-CP	N/A	$1560.00	$0.00
9/29/08	97799-CP	N/A	$1560.00	$0.00
10/3/08	97799-CP	N/A	$1560.00	$0.00
10/31/08*	97799-CP	N/A	$1560.00	$0.00
12/12/08*	97799-CP	N/A	$1560.00	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

*The requestor withdrew dates of service 10/31/08 and 12/12/08 leaving a sought amount of $4,680.00

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.203 sets out the medical fee guidelines for professional services rendered on or after March 1, 2008.
3. 28 Tex. Admin. Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 10/29/2008 and 11/7/2008 for dates of service 9/26/2008, 9/29/2008 & 10/3/2008

   - 216 – Based on the findings of a review organization.
   - 880-139 – Reimbursement has been denied based upon the recommendation of a peer review 100%
   - 150 – Payer deems the information submitted does not support this level of service.
   - 850-204 – Medical documentation provided does not support the service (or level of service) billed.
   - 900-030 – This charge was reviewed through the clinical validation program
   - W1 – Workers compensation state fee schedule adjustment
   - 850-107 – Initial allowance recommended in accordance with the state fee schedule guidelines.

   Explanation of benefits dated 3/6/2009 for date of service 10/3/2008

   - 197 – Precertification/authorization/notification absent.
   - 880-155 – Denied per insurance: No proof of pre-authorization provided.

Issues

1. Are there unresolved issues of medical necessity and does the submitted documentation support the services billed under CPT code 97799-CP?
2. Did the requestor obtain preauthorization for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. The EOB's dated 10/29/08 the requestor submitted support that CPT code 97799-CP for dates of service 9/26/2008 and 9/29/2008 are denied with reason code "216" (Based on the findings of a review organization) and "880-139" (Reimbursement has been denied based upon the recommendation of a peer review 100%). Neither the insurance carrier nor the requestor submitted reconsideration EOB's for these dates of service. The respondent did not submit any documentation with their position statement supporting denial reason "216" and "880-139". For date of service 10/3/2008 the requestor also billed CPT code 97799-CP x 8 units. The insurance carrier denied this service on the EOB dated 11/7/2008 with reason code "150" (payer deems the information submitted does not support this level of service) and "850-204" (Medical documentation provides does not support the service). The requestor's medical documentation for date of service 10/3/2008 does support 8 units of CPT code 97799-CP. The reconsideration EOB dated 3/6/2009 for this date of service supports denial reason codes "197" (Precertification/authorization/notification absent) and "880-155" (Denied per insurance. No proof of pre-authorization provided.)
2. The requestor states in their position statement "the preauthorization was already granted and listed medical necessity as the reason for granting the original request." However, the requestor's submitted pre-authorization approval dated 8/11/2008 for chronic pain management supports 10 visits with a start date of 8/11/2008 and end dated of 9/19/2008. The requestor also submitted a second preauthorization approval dated 11/24/2008 which supports 80 hours of chronic pain management between 10/15/2008 and 12/12/2008. The disputed dates of service 9/26/2008, 9/29/2008 and 10/3/2008 are not within the time frame approved by the insurance carrier. Therefore, reimbursement to the requestor for the disputed dates of service is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature	Medical Fee Dispute Resolution Officer	4/7/2011 Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.